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AMEND Senate Bill No. 2453 House Bill No. 2310*

by adding the following language as new Sections 2 through 13, and by renumbering Section 2 of the printed bill accordingly.

SECTION 2. Tennessee Code Annotated, Title 68, Chapter 11, is amended by adding Sections 3 through 13 of this act as a new part.

SECTION 3. The provisions of Sections 3 through 13 of this act shall be known as and may be referred to as the “Prenatal Care Initiative”.

SECTION 4. (a) It is the intent of the general assembly that a statewide Prenatal Care Initiative be implemented to ensure the availability and accessibility of prenatal care throughout the state of Tennessee. The initiative is to utilize the regional perinatal centers to monitor prenatal care within their regions, facilitate the development of appropriate prenatal care resources, and, where necessary, provide care in areas without local resources.

(b) This statewide plan is to be based on the integration of five (5) regional plans to address prenatal care which have sufficient commonalities to constitute a functional statewide plan. At the same time, each of the five (5) plans is to be tailored to the unique characteristics of its region. Each plan must be dynamic in that its purpose is to monitor and address a dynamic health care system which is continuing to develop under TennCare.

SECTION 5. The statewide plan referred to in Section 4 is to be based on initial proposals included in the Prenatal Care Initiative begun in December 1994 which has been compiled in a statewide report, *Maternity Care Resources in Tennessee, February 1995*. The department shall review the information contained in such report which also includes the descriptions of maternity care resources submitted by the regional centers plus information gathered from other sources, including the TennCare provider database, interviews with

regional health department staff, interviews with county health departments, and interviews with providers. For this report four (4) of the five (5) regional perinatal centers submitted a county-by-county analyses of maternity services within their regions. The regional perinatal center with the largest and most complex region, Vanderbilt University Medical Center in Middle Tennessee, submitted a plan to spend the first six to twelve (6-12) months of the initiative researching its region to develop detailed information on maternity services. The information gathered by the perinatal centers included the following information on each county: a list of hospitals which provide labor and delivery services; a list of obstetricians who provide services to TennCare patients; a list of family practice physicians who provide care to TennCare prenatal patients; a description of the prenatal services provided through the county health department; and descriptions of any additional providers of prenatal care such as primary care centers, maternity centers, private practice nurse midwives, or any other prenatal care resources which are available.

In addition to the information on maternity care providers, the regional centers have compiled statistical information on each county from sources such as the Statistical Abstract of Tennessee and the recently published Tennessee's Health: Picture of the Present. Information compiled includes demographic data (the total population of each county, the population of females of childbearing age (15-44), the percentage of the population with incomes below the federal poverty guidelines, and the percentage of the population which is of minority races); birth data (the total number of births, number of white births, number of non-white births, total birth rate (general fertility rate), white birth rate, and non-white birth rate); data on low weight births (the total number of low weight births, number of white low weight births, number of non-

white low weight births, the total rate (percentage) of low weight births, the rate of low weight births for whites, and for non-whites); data on neonatal mortality (the total number of neonatal deaths for 1990-92, number of white neonatal deaths for the period, and number of non-white neonatal deaths, total neonatal mortality rate for 1990-92, white neonatal mortality rate, and non-white neonatal mortality rate); and data on the adequacy of prenatal care in each county as measured with the Kessner Index using birth certificate data.

These sets of data are to provide a foundation for analyzing needs within each region and provide a baseline against which the progress of the Prenatal Care Initiative can be measured. The monitoring processes described in this act shall allow frequent updating of information on maternity care resources and will put the regional perinatal centers in position to recognize needs and mobilize resources to respond to the needs.

SECTION 6. (a) Each regional center shall be required to continue to gather information to monitor the maternity care resources in its region. This process is to involve communicating with many health care systems and providers to create and maintain knowledge of the availability and accessibility of prenatal care in the region. In each regional plan, a nurse specialist is to have responsibility for coordinating communication with providers and agencies and for gathering information on maternity services.

(b) A key element of monitoring prenatal care at the points of access is to be frequent contacts with physicians, county health departments, and other agencies providing maternity services. These contacts are to provide the opportunity to assess such issues as acceptance of presumptive eligibility, waiting times for appointments, waiting times for visits, and satisfaction with care. Just as the regional perinatal centers have maintained contact with physicians to

facilitate appropriate use of tertiary level services, under this initiative the perinatal centers shall have contacts with physicians to consult on issues related to accessibility and utilization of prenatal care at the primary level. Contacts with physicians are to range from regional conferences to on-site consultative visits. In addition, questionnaires are to be used to collect information directly from maternity patients. Guidelines for the site visits and a questionnaire for maternity patients shall be included as a part of this plan.

(c) In addition to contacts with the health care providers themselves, regional center staff shall communicate with the Community Health Agency or Agencies within the region and with the TennCare Managed Care Organizations serving the region. Such communication is to help to create partnerships for addressing unmet needs.

(d) The monitoring process shall also address resource utilization within the region, including consultation and referral patterns and linkages between primary care providers and delivery sites. The monitoring of resource utilization shall involve review of perinatal center data on consultations, chart reviews of tertiary level patients to assess appropriateness and timeliness of consultation and referral linkages, analysis of cases of deliveries occurring without prenatal care, and other processes developed by the centers.

(e) Each center shall maintain a 1-800 phone number to assure easy access to information on maternity services in the region for both providers and patients.

SECTION 7. (a) The information gathered to describe maternity care resources is to provide a basis for recognizing unmet needs for services. Unmet needs may include, but not necessarily be limited to, lack of health care providers, lack of hospital maternity services within a reasonable distance, physicians with an excessive number of patients with resulting lengthy

waits for initial prenatal visits, or other conditions which make services unavailable or inadequate. Analysis of unmet needs shall be an ongoing process and shall be an extension of the process which began with the December 1994 submission of proposals by the regional centers. However, such analysis can become functional only after resources are allocated to the centers to allow them to address problem areas within their regions.

(b) Access to care issues which have already been identified include:

(1) There are sixteen (16) counties in the state with no maternity care providers and an additional two (2) counties where the only services are provided via outreach from the regional perinatal center;

(2) There are counties in which there are no maternity service providers who are participants in one or more of the MCOs who have enrolled participants in the county;

(3) There are also counties with providers whose capacity to serve TennCare patients is not adequate in comparison to the numbers-of TennCare patients in the locality. This capacity problem results in significant delays in initiating care for many pregnant women;

(4) Many providers across the state do not honor presumptive eligibility for TennCare. Lack of care under presumptive eligibility also causes delays in initiating care for many pregnant women.

SECTION 8. (a) In addressing unmet needs, the regional perinatal centers shall be required to emphasize use of local resources as the best and most practical means of solving local problems. In many cases the regional center staff shall be consultative and supportive, acting as catalysts of change rather than building new systems themselves. In other cases, it

will be necessary for the regional perinatal centers to allocate staff to provide services where none are available.

(b) Some of the needs identified may be addressed through work to reorganize local resources and to provide support and back-up from the regional center. For instance, in a county which has nurse practitioners at the health department who are trained to provide prenatal care but have no medical back-up, the regional center may provide training support and medical back-up for the nurse practitioner while working with physicians in the area to provide liaison and delivery services.

(c) In counties where there are no resources for providing maternity services, a funding mechanism shall be developed to allow the regional center to send staff and equipment into the county on a regular basis to establish prenatal care. The funding mechanism may include charging the cost of care to the MCOs covering the county with each MCO paying a share of the costs in proportion to its percentage of TennCare enrollment in the county. Costs of providing care shall be detailed to include the staff, equipment, training, communication, and other resources required to address each of the situations of unmet needs.

(d) Each perinatal center shall submit a plan to address unmet needs and to revise such plan at least annually.

SECTION 9. Each of the perinatal centers shall have a nurse specialist who is to carry out the monitoring and consultative processes which is to be the foundation of the Prenatal Care Initiative. The nurse specialist shall be supervised by a perinatologist. Other staffing may vary from region to region depending upon the activities planned under the initiative.

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The Prenatal Care Initiative shall also benefit from existing staff in the regional perinatal centers. The regional perinatal center is to provide a core of expertise and experience to support the initiative.

SECTION 10. The Program Objectives Report (POR) used by the regional perinatal centers to report on their activities to the department of health shall be used by the centers to report on activities under the Prenatal Care Initiative. Data elements to be included in the report are: number of contacts with physicians about prenatal care access, number of calls to the 1-800 number, number of primary-level prenatal care visits provided by perinatal center staff. Additional activities may be added to this list as the initiative develops.

SECTION 11. (a) Each regional perinatal center shall carry out quality assessment studies to evaluate the effectiveness of the regional perinatal center's activities under this initiative. POR data, vital statistics, and quality assessment reviews shall be used for evaluation of the perinatal centers' work under this initiative.

(b) An early analysis of birth certificate data to allow monitoring of areas with high proportions of women getting into prenatal care late in pregnancy shall be developed

SECTION 12. Each of the five (5) regional perinatal centers shall submit an annual budget for the Prenatal Care Initiative. The budgets shall include personnel costs with fringe benefits and other expenses, including equipment purchases. Equipment includes clinical equipment to support provision of services and equipment to develop communication links between the regional perinatal centers and various primary care sites and hospitals.

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SECTION 13. The department of health shall promulgate necessary rules and regulations in accordance with the uniform administrative procedures act, title 4, chapter 5, to implement the effect and intent of this section.